prefer, the less intuitive term negative predictive value). Although the FN or false-positive rate is sometimes criticized for being influenced by the prevalence, this effect primarily occurs at extremely high or low prevalence (not in the range of prevalence among the patients in this study). As I calculate the results for all patients (regardless of size), the FN rate is 5%, 9%, and 7% for the C/T ratio, tumor disappearance ratio, and visual estimation methods, respectively. I wish the authors would report the FN rates for the three methods for tumors less than 2 cm. They have not provided enough data to allow this calculation to be made.

In addition, although vascular invasion and lymphatic invasion have been widely viewed as surrogate markers for tumor dissemination to nodes or distant sites in Japan, this has been less well adopted in other parts of the world. Furthermore, I would argue that the issue in question is local spread (i.e. nodal metastasis) when considering lobar versus sublobar resection (if distant metastasis has occurred, it will not be influenced by the extent of local resection). Therefore, I think that focusing on a surrogate such as vascular or lymphatic invasion may not be as relevant as the actual occurrence of nodal metastasis. I wish the authors would specifically report the incidence of nodal involvement for tumors with a C/T ratio, tumor disappearance ratio, and visual estimation ratio of less than 0.5 (for lesions of all sizes as well as only those <2 cm).

Once again, I wish to commend the authors for their substantial contributions to the clinical science of lung cancer.

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TABLE 1. Radiologic-Pathologic Correlation in Lung Cancer 2.0 cm or Less in Size (Cutoff: 0.5)

	Pathological Diagnosis[b]	
Radiology (Cutoff: 0.5)[a]	**Noninvasive**	**Invasive**
Consolidation/tumor ratio on lung window		
Noninvasive[a]	65	2
Invasive	145	77
Sensitivity	31.0% (95% CI: 24.8–37.7)	
Specificity	97.5% (95% CI: 91.2–99.7)	
TDR		
Noninvasive[a]	101	10
Invasive	109	69
Sensitivity	48.1% (95% CI: 41.2–55.1)	
Specificity	87.3% (95% CI: 78.0–93.8)	
Visual estimation of consolidation		
Noninvasive[a]	84	7
Invasive	126	72
Sensitivity	40.0% (95% CI: 33.3–47.0)	
Specificity	91.1% (95% CI: 82.6–96.4)	

TDR, tumor disappearance ratio; CI, confidence interval.
[a] Cutoff for the diagnosis of radiologic noninvasive cancer is 0.5.
[b] Pathological noninvasive is defined as adenocarcinoma with no nodal involvement, lymphatic invasion, nor vascular invasion.

JCOG0201 Defined "Radiological Early Peripheral Lung Adenocarcinoma"

To the Editor:

In our article entitled, "A Prospective Radiological Study of Thin-Section Computed Tomography to Predict Pathological Noninvasiveness in Peripheral Clinical IA Lung Cancer (JCOG0201)," we made a comparison between radiological findings of ground glass attenuation on thin-section computed tomography and pathological invasiveness such as lymph node metastasis. Sensitivity and specificity were evaluated in this article, and the definition of radiological early peripheral lung cancer was clarified for the first time. It is difficult for readers to interpret those data because of its unique method and mode for defining radiological early lung cancer.[1] However, Dr. Detterbeck's question definitely hit the nail of the head. We agree with him on that most surgeons need information on lymph node metastasis instead of vascular or lymphatic invasion. We actually prepared the data for submitting, but it was not possible for the limitation of the number of the tables. As to the false-negative cases for invasiveness in lung cancer 2 cm or less in size, the following table is added (Table 1). This table contains data on lung cancer 2.0 cm or less in size and cutoff of 0.5, that is, the size of consolidation less than half of the maximum tumor dimension. As to nodal invasion for radiological early lung cancer, we are preparing manuscript on this matter. We are sure to submit the information in the near future.

In addition, we have already conducted phase II trial named JCOG0804 for limited surgical resection for the "radiological early lung cancer" defined by the JCOG0201. Accrual of patients has just been completed, and we will conclude whether our criteria for early lung

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cancers are enough or not in the next 10 years.

We really hope that our prospective data would lead the world in better understanding the management for peripherally located early lung cancer.

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